RELIASTAR
ReliaStar Life Insurance Company

Evidence of Insurability Instructions

1. This Evidence of Insurability (EOI) form should already have your Employer's Name and the Group Number(s) preprinted on it. If this is not the case, check with your Benefits Person regarding your plan's Group Number. We cannot process your request for coverage without your Group Number.

2. If you are applying for Life coverage, your Benefits Person should indicate your current amount, the total amount you are requesting (including your current amount and any guaranteed amount, if applicable) and the amount that needs to be medically underwritten on the EOI form or should give you instructions regarding what these amounts should be. **If you have a question regarding the amount that requires underwriting, please contact your Benefits Person in your Human Resources Department.**

   IMPORTANT:

   The **"amount to be underwritten"** is the dollar amount of coverage for which you or your dependents must show **proof of good health**. This "underwritten" amount should **not** include any coverage you or your dependents may already have in force through this plan or any coverage that can be obtained through this plan without providing evidence of insurability. If the amount to be underwritten is incorrectly stated on your EOI form, you or your spouse may be asked to have an exam, blood profile or EKG that might otherwise not be necessary. **Note:** If there is **no** current coverage in force, state **"0"** in that column. Current, total and underwritten amounts need only be indicated on this EOI form for the family members who are applying for coverage at this time. **If not applying, the amounts in these columns can be left blank.**

3. Make sure that you give us all of the requested information. Answer all questions. Sign and date both sides of the Evidence Form at the bottom. Failure to do so may result in having your Evidence Form returned to you for completion and will definitely delay processing time for your request.

4. Complete **both sides** of the Evidence Form.

5. Indicate the **full names** and **complete mailing addresses** of the physicians listed. Attach an additional sheet, if necessary. Complete mailing addresses will greatly reduce processing delays.

6. **Make and keep a copy of both sides of the Evidence Form for your records.**

7. Read the "ReliaStar Life Insurance Company Insurance Information Practices Notice" (on the other side of these instructions) and keep it for your reference.

8. After completing your Evidence Form, **follow the instructions given to you by your Benefits Person**. They may request that you return your completed Evidence Form to your HR department or send it to your plan's Third Party Administrator, if applicable, or mail your Evidence Form directly to ReliaStar at the address on the **top right corner** of the Evidence of Insurability Form.

9. For general questions regarding completing this form or for checking the status of your underwriting once the EOI form has been submitted to ReliaStar, please call Special Underwriting at (612) 342-7262. However, **you must contact your Benefits Department if you have a question regarding amounts**. Special Underwriting does not have information concerning the amounts that should be indicated on your EOI form.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

ReliaStar Life Insurance Company
Insurance Information Practices Notice

We are pleased to provide you with information regarding this Evidence Form. This information is provided to you in accordance with legislation enacted in your state.

Our Underwriting Procedures

For certain types of coverage, we require proof of good health to determine if you are eligible for the coverage you requested. We review all of the information in the Evidence Form, and, if necessary, confirm or add to this information in the ways described in this notice.

Privacy and Information Practices

Collecting Information
Your Evidence Form is our main source of information. But we may:

- Ask you to have a physical exam, an EKG and/or a blood profile, etc.
- Ask physicians, hospitals, or other health care providers to confirm or add to the information you have given us. The types of information we may ask for are described on the authorization form you will be asked to sign. If you want a copy of this form, it will be given to you for your records.
- Obtain information from the Medical Information Bureau (MIB). See "Notice Regarding MIB, Inc." below.
- Seek information from other companies you have applied to for insurance.
- Ask you for additional information through use of a written request called an Amendment.

Information Use
We will use the information only for business purposes arising from the relationship you have with us.

Information Maintenance and Disclosure
We treat the information we have about you as confidential. The authorization form that you have been asked to complete will permit us to send the information to our affiliates and to MIB, our reinsurers, employees, contractors, or other organizations that process transactions concerning coverage you have with ReliaStar Life or its affiliates, and to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. In certain circumstances, the information we have about you may be disclosed to third parties without your specific permission.

Access to Information
If you request it in writing, we will send you a copy of the relevant information we obtain about you in connection with your request for coverage. Medical information, however, will only be disclosed through the attending licensed physician.

If you feel that any of the information in our file is not correct or is incomplete, we will review it. If we agree with you, we will make the corrections. If we do not agree with you, you may file a short statement of dispute with us. Your statement will be included any time we disclose this information to anyone.

We will not send you information we collect in expectation of or in connection with any claim or civil or criminal proceeding.

Notice Regarding MIB, Inc. (Medical Information Bureau)
We or our reinsurers may make brief reports to MIB. The reports will include the factors that affect the insurability of any person for whom coverage is being requested. MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may supply that company with any information in its file. If you ask, MIB will arrange to disclose to you the information it has about you in its file. If you question the accuracy of the information in MIB's file, you may contact MIB and ask them to correct it as provided in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's phone number is (617) 426-3660. We may also release information in our files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

Evidence of Insurability

RELIASTAR

ReliaStar Life Insurance Company
P.O. Box 20, ***Route 7812,*** *Minneapolis, Minnesota 55440*

ALL INFORMATION IN THE BOLD BOXES MUST BE COMPLETED. FOR QUESTIONS REGARDING PROPER AMOUNT TO BE UNDERWRITTEN, CONTACT YOUR HR BENEFITS PERSON. Please type or print in ball point pen.

Employee's Social Security Number	Employee's Name (*Please Print*) Last First Middle	Employee's Date of Birth	Employee's Sex
_ _ _ _ _ _ _ _ _	_____	_____/_____/_____	M or F

Group Number	Acct. No.	Name of Employer	Hire Date (Full-time)	Employee's Job Title	Annual Salary
GL-29888-3		**Contra Costa County** – ***Service Guarantee Plan***	____/____/____		

For life coverages: Enter the **dollar** amount of the guaranteed amount, the total **dollar** amount desired and the **dollar** amount of the **difference** between the total amount desired and the guaranteed amount.

		Guaranteed Amount	Total Amount Desired	Amount to be Underwritten	
Employee:	☐ Supplemental Life	$_____	$_____	$_____	
Spouse:	☐ Supplemental Life	$_____	$_____	$_____	**SUPP W/PORT PLAN**
Child(ren):	☐ Supplemental Life	$_____	$_____	$_____	

This EOI submitted due to: ☐ Initial Enrollment ☐ New Hire ☐ Late Entrant ☐ Increase – Explain:

Employee's Home Address (*Please Print*)			
_____ Complete Street Address (Include Apt. #, PO Box #, RR#, etc.)	_____ City	_ _ State	_ _ _ _ _ - _ _ _ _ Zip Code

Employee Home Phone #:	Employee Work Phone #:	Name and phone number of the Benefits person in the Human Resources Department:
( )	( ) Ext.	Name: **Employee Benefits Services Unit** Ph. No. (**925**) **335-1746**

Now, complete all of the following information:
List below only the names of persons **who must show proof of good health for coverage that needs to be underwritten as indicated above. NOTE:** If you are requesting coverage for a step-child or a child over age 18, please check with your Benefits person to make sure the child would qualify as an eligible Dependent under the contract terms of this plan.

Names of persons to be **underwritten at this time.** *Please print full name.* (Last) (First)	Relationship to employee	**Birthdate (*mo., dy., yr.*)**	**Present Height (ft.)**	**(in.)**	**Present Weight (pounds)**	Regular physician(s) - provide name and **complete** mailing address
Employee	**SELF**					
Spouse						
Child						
Child						
Child						

IMPORTANT! Please carefully read the next section. Then sign and date below.
I request the coverage indicated above on this Evidence Form under the Group Plan(s) sponsored by my Employer and authorize the required deduction, if any, from my wages. I declare that **all** of the statements and answers on **both** sides of this Evidence Form are **complete and true** to the best of my knowledge and belief. I agree that they shall be the basis for issuance of coverage under my Employer's Group Plan(s). I realize that any misrepresentation or omission regarding the presence of any pre-existing impairments and/or diseases may result in the requested coverage or benefits provided by such coverage being contested. I understand that any claim incurred prior to the approval of this Evidence Form by ReliaStar Life Insurance Company's Home Office will not be valid. **I certify that I have a copy of both sides of this Evidence Form to keep for my records.**

Date	Employee's Signature (*required*)

COMPLETE ALL MEDICAL INFORMATION ON BACKSIDE

NOTE: Answer Questions #1-7 below only as they pertain to the person(s) requesting coverage **AT THIS TIME.**

For each "yes" answer, state information below. (Please attach a separate sheet if additional space is needed.)

1. ☐ Yes ☐ No Has any person requesting coverage ever had or been treated for any of the following? Lung disorder; asthma; high blood pressure; heart trouble; nervous disorder; liver or stomach disorder; kidney or urinary disorder; diabetes; arthritis; cancer; alcohol/chemical abuse; depression; or any physical/mental impairment.
2. ☐ Yes ☐ No In the last three years, has any person requesting coverage had or been treated for any of the following? Ulcer; back/neck trouble; eye or ear impairment; any disorder or disease of the breasts, reproductive system or prostate; carpal tunnel syndrome; or knee disorder.
3. ☐ Yes ☐ No Has any person requesting coverage consulted a physician, received surgical or medical care or taken prescribed medication for any condition during the past 12 months (including current treatment)?
4. ☐ Yes ☐ No Does any person requesting coverage anticipate being under a doctor's care for any condition within the next 6 months?
5. ☐ Yes ☐ No Has any person requesting coverage had or been told they had, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS related complex (ARC)?
6. ☐ Yes ☐ No Has any person requesting coverage been previously declined by ReliaStar Life or any other insurance company?
7. ☐ Yes ☐ No Is any person requesting coverage currently pregnant? Expected due date: _____

Q #	Name of family member	Condition/illness/injury-type of treatment	Date of Treatment	Physician's name and complete mailing address (*include your medical or clinic ID number if any*)

Authorization and Acknowledgment -- Please read and sign below.

For underwriting and claims purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau (MIB), Inc., or employer to give ReliaStar Life Insurance Company (ReliaStar Life) or its authorized representative (including any consumer reporting agency) acting on its behalf ALL INFORMATION on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or any non-medical information as they apply to me, my spouse or any of my children who are to be covered. I give my permission to ReliaStar Life to get consumer or investigative consumer reports about the same persons.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42CFR Part 2. I may revoke this authorization as it applies to any information protected by this Federal Regulation at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB, Inc. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

I acknowledge that I have been given ReliaStar Life's Insurance Information Practices Notice and Notice Regarding MIB, Inc. (on back of the Evidence of Insurability Instructions).

Date	Employee's Signature (*required*)	
Date	Spouse's Signature (*if applying*)	Spouse's Soc. Sec. # (*if applying*)

EOI INSTRUCTIONS FOR BENEFITS PERSON

1. Enclosed is a master copy of the Evidence of Insurability Form (EOI) for your plan.

2. If you are not a new ReliaStar client, this EOI form **replaces** any version of the EOI form you may currently have. Please **destroy** any older EOI version that has "**Northwestern National Life**" printed at the top as well as any newer version showing "ReliaStar" at the top. **The enclosed EOI form is the correct and the only version of the EOI form that your plan should use, whether you are a new ReliaStar client or an existing client**. If you have any question or problem regarding this EOI form, please contact your ReliaStar Client Rep.

3. Using the master copy, please make copies of the entire EOI form as needed.
   There are 4 pages to the entire EOI form.
   Page 1: Evidence of Insurability Instructions
   Page 2: ReliaStar Life Insurance Company Insurance Information Practices Notice
   Page 3: Front side of EOI form
   Page 4: Backside of EOI form

4. Copying instructions:
   A. Make a 2-sided copy of page 1 and page 2 so they are copied back-to-back.
   B. Make a 2-sided copy of page 3 and page 4 (the actual EOI form) so that they are copied back-to-back. **This is extremely important so the front side and backside of the EOI form cannot become separated.**
   C. The 2-sided copy of page 1 and page 2 should always be stapled to the 2-sided copy of the EOI form (page 3 and 4) so that the employee gets the entire EOI form. **It is a compliance requirement for each employee to get all four pages regarding the EOI form.**

5. **IMPORTANT**:
   Stating the correct amount to be underwritten on the EOI form is **extremely** important. For this reason, we strongly suggest that the proper amounts be put on the EOI form **before** it is given to the employee to complete or that the completed EOI form be **returned to you** before it is submitted to ReliaStar so you can make sure the amounts are correct. Otherwise, you must **clearly instruct each employee as to the correct amount to be underwritten.** If no instructions are given to the employee regarding the amounts, the amounts they indicate on the EOI form will often be wrong, resulting in processing delays and unnecessary underwriting requirements being requested of them and/or their dependents.

   THE AMOUNT THAT NEEDS TO BE UNDERWRITTEN should **not** include any coverage the applicant already has in force through your plan or is grandfathered for or can get without showing proof of good health (such as if your plan has GI coverage or SI coverage or the employee can increase a certain amount or multiple of salary during the enrollment period, etc.). Also, the amount indicated on the EOI form should always be stated as a **dollar** amount, not as a multiple of salary such as "2X". Again, the **amount to be underwritten should only be the amount for which the applicant must show proof of good health at this time.**

   Example:
   An employee makes $50,000 a year and requests a total of 4X salary during the enrollment. He has 1X salary currently in force. If he can increase his coverage by 1X salary during the enrollment period without proof of good health, his EOI form should indicate:

Current Inforce Amount	Total Amount Desired	Amount to be Underwritten
$100,000	$200,000	$100,000

   Note: The current amount is what the individual already has plus what they can get without being underwritten. The amount to be underwritten is the difference between the total amount desired and the current amount.

6. Instruct employees to return their completed EOI forms to you or instruct them to send their EOI forms directly to ReliaStar or to your Third Party Administrator, if applicable. Regardless of the procedure you instruct your employees to follow, the completed EOI forms should ultimately be sent to ReliaStar for processing at the following address:

   For Self-Administered Plans:

   ReliaStar Life Insurance Company
   Box 20, **Route 7812**
   Minneapolis, MN 55440

IMPORTANT: **INSTRUCT THE EMPLOYEE TO MAKE AND KEEP A COPY OF THE COMPLETED EVIDENCE OF INSURABILITY FORM FOR THEIR RECORDS.**